



# Mississippi Medicaid Outpatient Prospective Payment System (OPPS) Payment Method

*Billing Quick Tips Effective July 1, 2019*

- Division of Medicaid (DOM) website: [www.medicaid.ms.gov](http://www.medicaid.ms.gov)
- For Provider Relations and Beneficiary Services assistance call 1-800-884-3222
- To check the rebate status for Physician Administered Drugs visit <https://www.ms-medicaid.com/msenvision/rebateInquiry.do>

## **KEY POINTS FOR SFY 20:**

1. Dental services changes:
  - Requires the **dentist** to obtain prior authorization for any dental procedures performed in the outpatient hospital setting.
  - Allow for the coverage of more than one (1) unit per beneficiary per day with prior authorization.
  - Require each approved unit billed as a separate line item.
  - Apply multiple discounting.
  - The hospital is responsible for obtaining the approved prior authorization from the dentist.

## **KEY POINTS TO CONSIDER:**

2. Single Claim for Single Visit. All services provided by the hospital to the same beneficiary on the same day must be billed on the same claim, except:
  - Claims for multiple distinct visits for the same beneficiary, same date of service, and same provider must denote condition code G0 (zero).
3. Span Date Billing. Multiple dates of service on the same claim for the same beneficiary is allowed only for specific services, with day limits:
  - Therapies (speech, physical and occupational): Limit of thirty-one (31) days, per calendar month.
  - Chemotherapy (claims billed with rev codes 0330-0339): Limit of thirty-one (31) days, per calendar month.
  - Observation (claims billed with procedure code G0378): Limit of three (3) days.
  - Emergency Department (claims billed with procedure codes 99281-99285): Limit of two (2) days, must include 'ET' modifier on line items of second day.
  - Recovery Room (revenue code 0710): Limit of two (2) days.

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- For more information on span date billing, go to <https://medicaid.ms.gov/wp-content/uploads/2016/10/OPPS-Date-Bundling-Provider-Billing-Guide.pdf>
4. Charge Cap. Claims will be paid the lower of the calculated allowed amount or the billed charges, with the comparison done at the claim level, not the line level, excluding denied lines.
  5. Medicaid National Correct Coding Initiative (NCCI). Outpatient claims are subject to NCCI edits (includes Procedure-to-Procedure [PTP] and Medically Unlikely Edits [MUEs]).
  6. Unit Edits. For all procedure codes for which a fee is paid, the payment will equal the fee multiplied by the number of units. If a claim line exceeds the DOM maximum units, the line will be denied.
  7. OPSS Status Indicators (SIs). SIs show how a claim is priced, whether it is covered, non-covered, covered but discounted, or bundled. The SI also indicates where a fee comes from, such as Ambulatory Payment Classification (APC), Medicare, or Medicaid. A list of OPSS SI is available in the fee schedule on the DOM website.
  8. Multiple Procedure Discounting. Applies when two (2) or more services with a status indicator “T” or “MT” are billed on the same date of service.
  9. Bilateral Pricing Policy. Claims with CPT/HCPCS codes that are inherently bilateral, have status indicator “T” or “MT,” or are billed with modifier 50, are also subject to discounting.
  10. Observation Services:
    - Must be included on a single line – even the hours that take place after midnight.
    - Paid a per hour rate for minimum of eight (8) hours and maximum of twenty-three (23) hours.
    - The first seven (7) hours are bundled and pay zero (\$0.00). Hours between eight (8) and twenty-three (23) will pay a fee.
    - Physician observation codes will not be paid if billed on the hospital claim.
  11. Physician Administered Drugs (PAD). These are “Drugs Requiring Specific Information” that must be billed with revenue code 0636, require a National Drug Code, and are only reimbursed if the drug is rebateable.

### **KEY POINTS NOT CHANGING:**

- Medical necessity reviews, unit limits and other service limits (e.g., eligibility).
- Outpatient physician services, therapy services, lab services.
- Services provided in community mental health centers and freestanding psychiatric hospitals.
- Hospital-based dialysis services are to be billed using the dialysis provider number, not the hospital provider number.

*\*\*\*Please note that these billing tips, while intended to be helpful, do not supersede applicable statutes, regulations and policies.*